One of the many failings that the Paterson Inquiry has exposed is around the issue of liability in the independent sector. Who pays when things go wrong? **Stephen King**, partner at national law firm Mills & Reeve, argues that pricing may need to change to better reflect the true cost of risk

The Paterson Inquiry report realistic pricing and risk

Outcomes, and especially patient outcomes, are centre stage in the provision of healthcare. Analysis of peaks and troughs, or 'outliers' as they are often known in clinical practice, reveals much about standards and the effectiveness of clinical practice and at quite a granular level. One can look to the Getting It Right First Time or GIRFT project being led by Professor Tim Briggs from the Royal National Orthopaedic Hospital, as an example where, with political support - and funding - it has been demonstrated that identifying outliers and requiring the concentration of resources, not only improves patient outcomes, but nurtures best practice.

One can look elsewhere for evidence to support a link between money and discipline. The Lloyds of London review of insurance underwriting over the last couple of years, following significant losses in some insurance classes, resulted in some insurance syndicates being forced from the market, or from underwriting particular classes of business. In essence, pricing the insurance too cheaply, and thereby undermining good underwriting disciplines. Losses followed as claims came in.

Unable to implement an effective recovery plan, or price their underwriting more appropriately, they have been prevented from participating in certain insurance markets.

We have written elsewhere about the true cost of managing malpractice claims in a healthcare context. These are claims emerging from poor patient outcomes caused by negligence.

For the purpose of this article we will look at what went wrong around what we all now know as simply 'Paterson'.

We will assume the background, widely reported years before the January 2020 report, in the Spire Hospitals Veritas report and the Sir Ian Kennedy report into the goings on at Heart of England NHS Foundation Trust, is understood.

The January 2020 report made a variety of recommendations, many of them unsurprising given the context reported (with recommendations) years earlier.

What none of these recommendations touch on expressly, and nor did the earlier reports, was money, cash, investment.

THE COST OF POOR PATIENT OUTCOMES IS MASSIVE, AND NOT JUST IN THE NHS

Owning the problem?

Consider where we are. The government has completed a consultation into how best to deal with escalating costs in medical malpractice claims, and another consultation on whether discretionary, non-contractual, unregulated, unenforceable indemnity arrangements (which make up the majority of indemnity arrangements for medical practitioners outside their NHS practice) should change. But the outcomes of those consultations have yet to emerge.

Why is that?

The costs of dealing with medical malpractice are ever increasing. In his commentary in the most recent NHS Resolution annual report, its chairman reports that: 'At current prices the annual cost of harm [in the NHS] was about £7bn to £8bn in recent years.

In 2018/19 the cost of harm was approximately £9bn, of which approximately 60% related to maternity claims, the increase being largely attributable to the impact of decreasing discount rates.'

He also reported that the claims provision has now increased by 'a further' £6bn to £83bn and went on to commend a strategy (which is yet to emerge) to tackle the costs of dealing with such claims.

The cost of poor patient outcomes is massive, and not just in the NHS. Does the NHS or the wider healthcare provider economy own a solution, or just a problem? You decide.

Redress

Now let's look at redress. What hit the fan spectacularly with Paterson was the realisation of two things:

First, that indemnifiers of Paterson (at least in his private practice) in that case the Medical Defence Union, would exercise its discretion (as it was perfectly entitled to) to decline him an indemnity for the raft of claims that emerged against him.

Second, that Spire (though they were not the only hospital group where Paterson operated) would be exposed to liabilities it never expected to have to deal with.

In fact, many surgeons, like Paterson, remain 'self-employed' contractors when

they are working in the independent sector. They are given 'practising privileges' whatever they mean, and are required to ensure that in accordance with GMC rules, they carry adequate and appropriate indemnity in case a patient is injured and pursues them for redress. So, typically the surgeon is carrying the potential liability for malpractice, not the hospital.

Pricing and contracting

That model, of expecting the surgeon to carry the risk, is the reason why across the country, so many independent for profit or not for profit providers of healthcare have not insured themselves to cover the malpractice of the surgeons (or other self-employed clinicians) who practice at their hospitals and clinics.

As far as they are concerned, at least until relatively recently thanks to Paterson, they can divert any claims for redress to the surgeon.

And that means that they do not price their services, whether for health insurers or the NHS who may contract with them, to include what I will describe as the actual cost of indemnity.

Of course, what has happened with Paterson and other situations where for one reason or another the surgeon has found indemnity declined, is that the courts have been asked to look at the gap in the availability of redress, at least in the independent sector.

The courts have been quick to clarify and develop the law around both vicarious liability and a non-delegable duty of care, which in general terms will fix a clinic or health provider with liability for the negligence of the surgeon, even if they are described by and contracted to the clinic or provider as 'self-employed'.

The reason? In a nutshell, the surgeon, by doing what they do, is furthering the commercial interests and business of the clinic or hospital.

Due diligence

So what I draw from this, though some may disagree, and I confess it is not the only conclusion of this sorry saga, is that pricing around healthcare provision, where margins are tight, especially over the past ten years or so as 'austerity' has bitten into budgets, has allowed an indemnity model to be seen as the norm, when it was quite obviously not fit for purpose.

That it was such a surprise to some organisations to find that they were exposed to liabilities they had not considered, nor covered themselves for, simply demonstrated a failure in risk management and governance that is at the heart of the various reports that have emerged from Paterson.

Audit and learning

Indemnity, like anything else, is a market of supply and demand and based on risk management. Insurers are familiar with the idea of 'presentation of risk'.

I suspect there is a heightened awareness now among healthcare providers about what that means.

The true cost of managing indemnity needs to be understood by those involved in the provision of healthcare. Contracts that provide for a broken model where the pricing of tariffs does not take account of the true cost of risk need changing, and part of that change is within the recommendations in the January report.

Investment is needed around risk management. What was acceptable, should not have been.